

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

454 1/21/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  JEFFERSON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 914 INDUSTRIAL PARK RD DANDRIDGE, TN 37725	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to respond to a resident's repeated calls for help, resulting in an incontinent episode for one resident (#26) of twenty-six residents reviewed.</p> <p>The findings included:</p> <p>Resident # 26 was admitted to the facility on December 8, 2008, with diagnoses including, Dementia, Psychosis, Adult Failure to Thrive, Dysphasia, Peripheral Neuropathy, and Status Post Above Knee Amputation.</p> <p>Medical record review of the Minimum Data Set, dated November 21, 2011, revealed the resident was cognitively impaired, with deficits in memory, and decision making, and was dependent for activities of daily living.</p> <p>Observation on December 6, 2011, at 2:28 p.m., in the common area outside the resident's room, revealed the resident calling out for assistance, "hey, hey, come here" repeatedly. Continued observation revealed two staff members in close proximity to the resident as the resident continued calling out for assistance. Further observation on December 6, 2011, from 2:28 p.m. to 2:47 p.m., outside the resident's room, revealed the resident</p>	F 241	<p>Staff members will respond in a timely manner to resident #26 when they request assistance.</p> <p>Staff members will respond in a timely manner to all residents when they request assistance.</p> <p>An in-service will be conducted with all staff on December 26-27, 2011 regarding answering call lights or calls for assistance in a timely manner.</p> <p>This issue was addressed by the Quality Assurance Committee at its December 16, 2011 meeting and will be reviewed for compliance periodically thereafter. A study will be conducted to measure compliance/effectiveness following the planned in-services. On-going compliance will be monitored by the Administrator, Director of Nursing, Unit Supervisors, Shift Supervisors and Charge Nurses.</p>	12/30/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Roger L. Mynatt

Administrator

12/20/11

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 continuing to call out for assistance, and at 2:47 p.m., the resident began calling out, "I'm wet now, come here", repeatedly.  Continued observation outside the resident's room, at 2:50 p.m., revealed, Certified Nursing Assistant (CNA) #1, entered the resident's room.  Further observation and interview with CNA #1, on December 6, 2011, from 2:50 p.m. to 2:52 p.m., in the resident's room, revealed the resident had an incontinent episode, and confirmed there was a 22 minute delay in responding to the resident's repeated requests for assistance.	F 241			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on medical record review, review of manufacturer's instructions, observation, and interview, the facility failed to instruct resident #20 prior to use and failed to follow manufacturer's recommendations after use for use of inhalants for one (#20) of twenty-five residents reviewed.  The findings included:  Resident #20 was admitted to the facility on September 22, 2007, with diagnoses including Asthma.  Medical record review of the Minimum Data Set dated November 20, 2011, revealed the resident	F 281	Each LPN administering medication by inhaler to resident #20 will instruct the resident based on manufacturer's recommendations, including the proper procedures before and after use.  All residents receiving medications by inhalers will be instructed by the LPN based on manufacturer's recommendations, including the proper procedures before and after use.  Nursing staff will be in-serviced on 12/28/2011 regarding the proper procedures for administering inhalers by the Consultant Pharmacist.  This issue was addressed at the December 16, 2011 Quality Assurance Committee meeting and will be reviewed for compliance periodically thereafter. On going compliance will (continued on next page)	12/30/11	

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F 281	<p>Continued From page 2</p> <p>had a Brief Interview for Mental Status (BIMS) score of 15 which indicates the resident is cognitively intact.</p> <p>Medical record review of the Physician's recapitulation orders for December 2011, revealed "...Advair (type of inhaler)...give one inhalation every day..."</p> <p>Observation of the Licensed Practical Nurse (LPN) #2 in the resident's room on December 6, 2011, at 8:15 a.m., revealed LPN #2 administered the Advair and failed to give instruction on medication use prior to administration. Continued observation at this time revealed the resident took one quick puff without holding the breath and handed the Advair back to the LPN.</p> <p>Review of facility policy, Oral Inhalation Administration, revealed "...6. Instruct the resident to...breathe out through mouth...8. Instruct resident to inhale slowly...11. Have resident rinse...mouth and spit out the rinse water..."</p> <p>Review of the manufacturer's instructions revealed "...Rinse your mouth with water after breathing in the medicine. Spit the water out. Do not swallow..."</p> <p>Interview with LPN #2, at the 200 hall nurse's desk, on December 6, 2011, at 8:30 a.m., confirmed the facility policy and manufacturer's instructions were not followed.</p> <p>Interview with the Director of Nursing (DON) in the conference room, on December 6, 2011, at 2:30 p.m., confirmed the facility failed to follow the policy for oral inhalation administration.</p>	F 281	(continued from previous page) be monitored by the Director of Nursing and R.N. Unit Managers. The Consultant Pharmacist will also monitor for compliance through Medication Pass Observations.		

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F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to provide appropriate treatment and services to prevent aspiration pneumonia for one resident (#22) of twenty-six residents reviewed.</p> <p>The findings included:</p> <p>Resident # 22 was admitted to the facility on August 31, 2010, with diagnoses including Spinal Cord Injury, Depression, and Peg tube Placement.</p> <p>Medical record review of the Physician's recapitulation orders for December 2011, revealed "...give 30 cc (cubic centimeters) water flushes before and after medications..."</p> <p>Observation on December 6, 2011, at 9:15 a.m., in the resident room, revealed Licensed Practical Nurse (LPN) #3 administering the 30 cc water flushes. Continued observation at this time revealed LPN #3 completed the medication pass and failed to verify proper positioning of the</p>	F 322	<p>Each LPN providing tube feeding services for resident #22 will provide appropriate NG treatment and services to prevent aspiration pneumonia. The nurse will verify proper position of the feeding tube prior to water and medication administration.</p> <p>Licensed Nursing staff will provide appropriate NG treatment and services to residents to prevent aspiration pneumonia. Nurses will verify proper positioning of the feeding tube prior to water and medication administration.</p> <p>Nursing staff will be in-serviced on 12/28/2011 by the Director of Nursing and Consultant Pharmacist regarding the proper way to administer medication through a feeding tube. The in-service will also cover the policy and procedures for tube feeding and include return demonstrations to ensure compliance.</p> <p>This issue was addressed by the Quality Assurance Committee at the December 16, 2011 meeting and will be reviewed for compliance periodically thereafter. On-going compliance will be monitored by the Director of Nursing and R.N. Unit Managers.</p>	12/30/2011	

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F 322	Continued From page 4 feeding tube.  Review of facility policy, Tube Feeding Administration, revealed "...Note: Verify proper positioning of feeding tube..."  Interview with LPN #3 outside the resident room, on December 6, 2011, at 9:28 a.m., confirmed the feeding tube placement was not checked prior to water and medication administration.  Interview with the Director of Nursing (DON) in the conference room, on December 6, 2011, at 2:30 p.m., confirmed the facility failed to follow the policy for tube feeding administration.	F 322			
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a sanitary environment in the dumpster area related to the improper disposal of a used and discarded resident mattress. The findings included: Observation of the facility dumpsters and surrounding area on December 5, 2011, at 10:10 a.m., revealed a soiled and used resident mattress had been discarded on the ground, behind and between dumpsters #1 and #2. Interview with the Administrator and Dietary Manager, on December 5, 2011, at 10:18, in the main lobby, confirmed the mattress had not been appropriately discarded for removal by sanitation	F 372	The facility will maintain a sanitary environment in the dumpster area. All mattresses will be appropriately discarded for removal by sanitation services.  This area will be monitored by the Administrator, Director of Environmental Services, and the Dietary Manager on a daily basis.  This issue was addressed at the December 16, 2011 Quality Assurance Committee meeting and will be reviewed for compliance periodically thereafter.	12/30/2011	

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F 372	Continued From page 5 services.	F 372			